THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF CONSENSUS GUIDELINES FOR THE PROMOTION AND MANAGEMENT OF CONTINENCE BY PRIMARY HEALTH CARE TEAMS

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SUMMARY

This project was undertaken as part of the N.H.S. Executive Strategy for Major Clinical Guidelines. It has involved the development of national Clinical Guidelines for the Promotion and Management of Continence by Primary Health Care Teams (Button et al 1995) through the process of managed consensus based on scientific review. The guidelines were then implemented at Castlefields Health Centre, an urban, first wave fundholding general practice in the North West of England, with approximately 12,000 registered patients. This report outlines the development and implementation of the guidelines and then presents the study undertaken to evaluate the impact of the implementation on clinical outcomes.

Various issues were identified during the implementation of the guidelines and most of these were successfully addressed. These included the production of a single assessment tool which interfaces with the computerised record keeping system, facilitating clinical audit of patient records regarding incontinence in the future. Screening for those in 'at risk' groups has been implemented, by including questions on incontinence in the screening of people aged over 75 years and at cervical cytology clinics. Educational and training needs of members of the Primary Health Care Team were identified and were being met. The members of the Primary Health Care Team were committed to the guidelines and intend to continue their implementation and evaluation through audit in subsequent years.

The evaluation of the impact of the implementation of the guidelines on clinical outcomes was achieved through a study involving a pre and post-implementation postal survey of a random sample of 17% of the patients aged 18 years and over from Castlefields Health Centre. The pre-implementation survey determined the period prevalence for the practice of urinary and faecal incontinence and related epidemiological data. Baseline data on the pre-implementation management of incontinence was also obtained and incontinence sufferers were invited to have their condition assessed and care reviewed. All incontinence sufferers who agreed to participate in a further study were sent the post-implementation survey, which identified those patients who had sought help, and ascertained patients' reasons for not seeking help. Further data on the management of incontinence since implementation of the guidelines was then obtained.

The clinical outcomes used to evaluate the impact of the implementation of the guidelines were the validated severity index for urinary incontinence (Sandvik et al 1993), which was also modified for faecal incontinence, and whether or not the patients perceived their incontinence as a problem. These outcomes were measured pre and post-implementation. A three month time period was allowed between pre and post -implementation surveys.

A 61% response rate was achieved from the pre-implementation survey, generating a relevant sample of 909 patients aged between 18 and 94 years, there were no significant differences in the numbers of males and females. There were significantly fewer people aged 18 - 29 years and more aged 40 - 64 years who participated in relation to the numbers in the practice population. Of the 225 people who were incontinence sufferers, 174 agreed to participate in the post-implementation survey and a 69% response rate gave a sample of 119 patients. Those who responded were representative of those who had agreed to be followed up.

The pre-implementation survey provided useful epidemiological data on incontinence for the practice. The period prevalence for reported urinary incontinence in the previous two months was 9.6% for males and 35.1% for females, and 7.3% for males and 21.5% for females for *regular* urinary incontinence (loss at least once a month). 6.5% of males and females reported faecal incontinence in the previous two months, 3.8% males and 3% females suffering *regular* faecal incontinence. The period prevalence for double incontinence was 4.4% for males and 4% for females, *regular* double incontinence reported by 2.4% males and 2.3% females. The data confirmed the findings of other studies, that incontinence is a common condition, urinary loss being more prevalent in females and with age, and related to birth and pregnancy. The majority of incontinence sufferers experienced only slight incontinence and most did not consider it to be a problem.

The survey also showed that only a minority (39%) of sufferers had sought help for their incontinence and that seeking help was directly related to the severity of incontinence suffered. Data obtained on the pre-implementation management of incontinence demonstrated that the approaches used by members of the Primary Health Care Team were not always those recommended by Button et al (1995) in the Consensus Guidelines.

This study confirmed previous research which showed that few people respond to invitations to seek help for their incontinence, as only a minority (16%, n=19) reported seeking help, of whom only four were presenting for the first time. Reasons given for not seeking help included that the incontinence was not a problem, embarrassment and lack of understanding, in line with other studies.

The guidelines were not found to have had any positive impact on the clinical outcomes of severity of incontinence and perception of the incontinence as a problem, although some slight improvements in the approaches taken by members of the Primary Health Care Team to the promotion and management of continence were recorded. Further evaluation of the impact of the guidelines on these outcomes is therefore recommended in the future, using the data from this study as a baseline.